EIPRP Meeting Minutes

Date of Meeting: January 25th, 2007

Type of Meeting: Standing Committee
Facilitator: Tom Simpatico, MD
Note Taker: Adriana Cheever/Recorded
Attendees: Jane Winterling

Agenda Topics: Jane Winterling, Vermont Psychiatric Survivors; Tom Simpatico, Medical Director; Michael Sabourin; Dr. Batra, Brooks I Clinical Director; Anne Jerman, Nursing Coordinator

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Discussed: Smaller acute care units.

Jane Winterling- Stated smaller acute care units would be very unique but there would need to be a lot more tolerance on these units. She felt that it would also be a very expensive to run and so you wouldn't want people there for long periods of time nor would they **want** to be there for long periods of time.

Tom Simpatico- Stated that we had actually looked at a smaller unit model probably about two and half years ago and felt it would not necessarily always be in use, but if it were in use, you would have to staff it like it's own unit or it would be technically considered a restraint unit and the logistics of doing this and building this type of unit were very challenging but we did look at a model of this.

Anne Jerman-Stated we had looked at that here, and that in order to that here, because of the required space that it would require, we would actually have to take four beds off the census of the current so it would have decreased our capacity of four beds.

Jane Winterling-Felt that the State should look at this option because if the State is trying to move in another direction as it states it is, she felt this was really important to consider as an alternative given the size of our State, that having a unit where five would be the maximum census would be valuable.

Tom S-Tom thought the group should know that we have been having some preliminary discussions about the new structure of a new facility and what that environment would be like, wherever that facility may be located and that this concept is absolutely part of the design and having flexibility in the space to be able to sort of partition areas off as needed as part of the design.

Tom S- Felt this was a good segway for initial discussion of this other sort of acute care patient that we working with that is currently in belt and wristlets, and again this poses interesting questions.

Jane Winterling-Jane Winterling wanted to add one further point on the discussion of smaller acute care units. She stated that she would never forget Dr. Munson's plea for one of his patient's and saying "when he comes out of this, I know he is going to be horribly ashamed and humiliated by what has happened to him." Jane felt that there was something to say for the kind of privacy that this allows people who are that ill in terms that it doesn't have to be quite so public and I think in terms of their healing that would also be a really positive thing as well. That there is some confidentially in that and maybe that's good. I think that's a big peace for a lot of people. It's very hard to come to terms with what you've done when you're sick.

Conclusion:

Action:

Person Responsible: **Due Date:**

Discussed: Case study

Dr. Batra-Dr. Batra talked about a patient who is from Connecticut, Standford area. He is in his mid 30's. He was in Rockingham briefly at a vacation home with his family. He is quite paranoid about people breaking the home, decided to throw computer into the TV. He said that he wanted to destroy the house himself rather than have drug dealers destroy the house. He came to the medical attention at the Brattleboro Retreat first and was transferred here because he assaulted one of the staff there. He has a long history of illness, at least 20 years or so. He is much worse since his mother passed away which was three or four years ago.

He was relatively better early on into his hospitalization, he had been doing quite well, graduated college, got admission into law school and then stopped taking his medications, he was somebody who was very heavily into substance use, starting using alcohol and drugs excessively and so this incident happened four to five months following starting the heavy drug use. He came here, and there

were two incidents early on where he had altercations with other patients and their were injuries toward other patients because of his paranoid beliefs and since then there have been five very severe assaults on staff for all kinds of reasons most of which were not given by the patient, in other words he was not able to say what led to it and what happened when he assaulted staff. In one of the incidents he asked one of the staff members if he knew how to fight and the staff member asked to repeat himself because he didn't quite follow him, the next he knew he was being punched in the face leading to a bone fracture. A couple of incidents, when someone was sitting as a one to one observation outside someone's room, in a chair in the middle of the night, he became assaultive without any kind of incident happening, no provocation, no conversation, nothing to really proceed that altercation whatsoever. A couple of times he was outside on smoke break, or walking in the hallway or anyplace and one time he got really upset with his brother because he wouldn't buy him a truck, smashed the phone down, and was asked to go back to his room because he looked really agitated and really upset, so this wouldn't disrupt everybody else watching TV and he took a swing at the person was on constant observation with. Dr. Batra stated that there had been a lot of assaults and the last one was an incident with someone on the night shift, he repeatedly hit the staff on the head leading to serious injuries.

One to one observation was started and this seemed wasn't enough and we went to two to one observation, there were always two people with him at that time but despite having two people constantly with him he was assaultive. The biggest problem was there was no way to predict these incidents. They could be anywhere between a week to three or four weeks apart. There is no way of knowing when the next one would happen, what would precede it, what kind of things we could look for, there would often be no signs of agitation until the assault would happen. No explanations given or very paranoid reasons given, believing at times that somebody or staff were sexually soliciting him by moving their legs a certain way or other doing other movements to solicit him.

We got to the point where there was no predicting what would happen, he consequently agreed to go into belts and wristlets and has actually been in belts and wristlets since the 5th of January.

Tom S- explained that belt and wristlets is a belt that goes around one's waist with a short leather strap and a couple of leather wristlets that have two short chains, so the person is then able to walk freely around the unit, their walking is not impeded, they are able to essentially walk around and able to feed themselves, write, but actually lashing out at somebody else is a lot harder to do.

Dr. Batra-Dr. Batra stated that even since being belt and wristlets, he has talked about how many ways he could be actually assault staff, like if somebody was sitting down he could strangle strangle them.

Jane Winterling-Asked if his diagnosis was Schizophrenia and was he hearing voices.

Dr. Batra-Dr. Batra explained that he has Bipolar Illness with psychosis and also has a long criminal history with similar assaults.

Mike Sabourin-Asked if it were a psychosis or pathological. Mike Sabourin explained that sometimes people just do things a certain way and there is nothing you are going to do with medications that change the way we behave. Like a sexual deviant. And sometimes things that are in their heads are there temporarily. Sometimes when they are off medications what the typical behavior is, they have withdrawal symptoms which is an enhancement of the illness. Mike Sabourin wondered in this case how receptive the patient is to the meds that he is on. It sounds like things are not under control. Yes he is in belts and wristlets but is sounds like things aren't working in the whole spectrum and how do you approach that.

Dr. Batra- Dr. Batra stated that he prefers to take one medication, but it doesn't help him nearly enough. He has not been taking a mood stabilizer or antipsychotic that has a history of having helped him in the past.

Tom S-Stated that so far the answer to the question is, there is a strong correlation to his having taken a particular combination of medication in the past that fairly sustained him for periods of time and helping not to exhibit this kind of behavior.

Mike Sabourin-Asked why he was saying refusing these medications now. Mike Sabourin felt sometimes he might say no for reason and sometimes he might say yes to something else.

Dr. Batra-Dr. Batra explained the reasons generally he has given is that he feels he is fine and that he doesn't need them or another reason was that it caused sexual side effects, which he is right about, but he was offered discussion about alternatives to cut back on that side effect or monitoring dosing so that we can avoid that kind of side effect.

Jane Winterling- Jane Winterling commented that she was in Australia at a conference and they did a conference on sexual side effects. It was actually begun by male consumers who said that this was a serious problem in their lives and one of them was 20 something years old and he couldn't get an errection, stated that he would like to have a girlfriend, and there were several men who went through similar episodes like this and finally started to come to together as a group of people. On this panel you had consumers and you had psychiatrist talking about prescribing medication and dealing with sexual side effects. Jane felt it was fascinating in terms of how they dealt with it in terms of treatment and therapy, and in terms of medication and how consumers were coming together and creating support groups for each other around this very issue. Jane wondered if something like this is talked about with these men here.

Dr. Batra-Dr. Batra stated it is discussed quite often.

Tom S-Asked if what she was saying that even though we discuss quite often like anybody else, there may reluctance to go into explicit detail about that particular side effect when in fact it may the thing that is most important in preventing them taking medication.

Jane Winterling-Jane stated that it is interesting in that we do a Retreat Support Group and often times when we talk about medications, they talk about sexual side effects and she had one consumer come up to her afterwards and say to me, "I'm ready to commit suicide, I have not been able to have a sexual relationship for twenty years and I have never been able to talk to my doctor about it and if I have tried, he says " but you have this illness and that doesn't matter."

Tom S- Stated that his association to what Jane was saying is that there is a variety of ways of thinking about that. He stated that we are rolling out the UCLA Social skills module. One of the modules actually gets at that in a very explicit way and it provides a structured way of really helping to create one hopes a comfortable environment in which that can actually be discussed. Tom felt that it might not be a bad idea for us to target that and put that higher up the deployment list and look specifically to see how that correlates with people's words.

Jane W- Jane stated that the other thing they do in terms of looking at treatment is to begin to have conversations about sexuality in our culture and what that means and its anthropology. Jane talked about a social worker who did a lot of work with physically disabled people who are paraplegic and talking and teaching them how to have very active sexual lives and these people are in a wheelchair, they have no function. Jane felt that in much of our culture sexuality is taboo; it's not something that is not talked about.

Michael S- Mike Sabourin stated that even talking about doesn't do away with the frustration. He stated that he was sure they talked about it here and can talk about here, but it doesn't designate the problem in that sense. Mike was wondering in the case here, if the person had any dialogue about this, or is there no just any dialogue about this and the person says no. Mike asked what he ever says yes to. What are other alternatives like even a traditional setting? Even though he is in belts and wristlets is anybody walked him around the grounds or just to get fresh air. What are things to prompt different responses? Mike felt that sometimes it just like in one routine and you get the same responses, changing the environment or changing the players or something like that, who knows what's going to happen.

Anne Jerman- Felt these were good points. She stated we work pretty hard here to address and broaden the idea of first all about side effects. She felt we do a reasonable job here and certainly we can do better at any time to understand when somebody says I don't want to take my meds because of this side effect or that side effect or for any series of reasons to really understand what it is about

those reasons that it is really interfering with the person's ability to say yes to the medication or understand that and then to be able to problem solve to try something and that we might able to offer help with the symptoms or help with the illness and that is a wonderful thing if we could do that or sometimes as Dr. Batra was saying, there really is only a couple of medications that the person responds to. And then the work is to do therapy around that and that they may have to live with some of these side effects what ever they are, and that there is something else they can do to bring some satisfaction to their lives, whatever that side effect might be. She felt this is not just about the sexual side effects but it really it is about all the side effects, because there are other side effects such as weight gain, headaches, and all sorts of things that are really upsetting to anybody, and understandably so. She felt our job is try to work with that and do the best we can not to minimize it, then people feel unheard and they are going to stop talking to us about everything, so we have to pay attention to those things, and then as Michael was saying, it's our job to the best we can to understand any problematic behavior or behavior that interferes with person's ability to get on with their life, to understand what are the things that decreases behavior and what are the things that increases that behavior, so that we can stop doing the things that make it worse and do more of things that make it better. Anne felt that kind of analysis takes time to understand these things because it is so individualized for some people just as you say, getting them outside, that is the exact thing they need, but Anne felt personally, if she was here and you took her outside she would be furious and it would make worse because she doesn't want to go outside so it's our job to understand with this particular individual wants and what we can do to help this person move on.

Jane W- Jane stated that when patient's get here, it's for a lot of this stuff, and it's often too late, and you just have to help them get better.

Anne J-Stated that was true and we can't bend because we have to let get them better so that we can begin to have the conversation when they are a little better, and how can we understand what got them here in the first place so that they don't come back here.

Jane W-Agreed, and felt we needed to inform the outpatient also because there is a number of people talking about disconnect between inpatient and outpatient and it was reported that some patient's say "well you know I come into the hospital and I get my medication straightened out and I feel better, it takes about three weeks, go home, my outpatient Doctor says "I don't like this" and starts changing them all around, despite what I have to say and here I am back in here again and another three weeks."

Tom S- Stated he would like to make a proposal. It would be nice to have bigger attendance at these meetings. He asked if we (members of the committee) want to have our mission of this group remain precisely focused on restraints and seclusion, emergency involuntary medication at the Vermont State Hospital or do we want to broaden the scope of this group to as a natural extension of that to also discuss precursors for people lining up in a position where they are using restraints and seclusions and emergency involuntary procedures, namely how long it takes to have people receive non-emergency involuntary medications once there here,

which correlates with their use of these other things, also once people are released from here what do we want, do we want to have conservations about going out, stopping medications and then coming back in and repeating those cycle where there doesn't seem to be an ability to prevent people coming back into the same place that they just left and in the meantime doing things like going backwards in their lives and damaging their lives. He asked the group, do we formerly say, we would like to include those topics as items that we formally look at and discuss on regular basis as they relate to the use of restraints, seclusions and emergency procedures at the hospital, and maybe there is no short answer but maybe there is. We'll discuss it the next time and come up with an answer. What are people's reactions to that?

Jane W-Stated that in part she hated to think of anybody getting hurt. She stated it's not that you can just look at a thing in particular and go well, don't do that anymore without looking at well then what else you can do? That's a horrible place to be in, you know if you don't have any place else to go. So it would seem to make sense to her that would be the way to go and you know it may be looking at ways to come up with better discharge planning. But she certainly doesn't have the answers to that.

Tom S- Asked so for example to look in this sort case, we might look at someone who is on their return flight after three year period and clearly not able to get State philosophy and they keep coming back in, we might want to look what plans are put in place when someone leaves.

Jane W-Stated she knew that years ago, people would just end up walking through door and here's so and so from the State Hospital and it might be Friday afternoon and have no medication, nobody knew they were coming, no housing and that's not a good thing.

Tom S-Asked the group that this will be clearly something that we decide at the next meeting.

Jane W-Stated that as we are starting to build these bridges within the community we can inform each other and to inform the system and the law makers because your hands in some ways are tied when somebody is that sick.

Tom S-Stated that he was going to send out a group communicate and ask the group to think about other people who we might approach or re-approach to participate in this process. He also stated we were going to have telemedicine hook up here and once that happens we might want to invite people at the University or elsewhere that we tap into and participate in this process and that might be interested, but to think about broadening the participation of the process.

Jane W-Stated as we look at this, because sometimes you present these cases, we can actually talk about things that you see as a need that you don't have the ability to put in place for whatever reason, and that kind of data I think is as important as how many seclusions

and restraints because that's what's going to inform the future of treatment. If we collect data that every person who comes here who is a outlier and say that if we had this in place, we think we could have avoided, then she thought we got some really strong data there.

Tom S-Proposed to do that next month, we will look at somebody and we'll not only look at being here and this environment. We have a wish list, what other things were in place, what can be avoided for this.

Jane W-Agreed and also stated we could find out how the community or the community and agency inform when there is a disconnect in the relationship.

Mike Sabourin-Maybe another conversation could be done in the community for people that are out of here for five years. There are people here that are outside of medical issues.

Conclusion:

Action:

Person Responsible: **Due Date:**